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Commentary

Maurice R. Hanson, M.D., Department of Neurology, The Cleveland Clinic Foundation, comments: Of the many patients who present with complaints of syncope and presyncope, a small but important subset will do so because the systemic blood pressure falls to levels that fail to maintain adequate cerebral perfusion in the upright position. Most of these patients will prove to have hypovolemia, effects from drugs, poor conditioning, or peripheral nerve disease. A smaller percentage of patients will have no apparent cause and may be suspected of having idiopathic orthostatic hypotension (IOH). An even smaller percentage of these may have a multisystem neurologic disorder including Parkinsonian features, cerebellar dysfunction, and spasticity—referred to as the Shy-Drager syndrome—a progressive disease with a serious long-term prognosis.

Effective and appropriate treatment for orthostatic hypotension is dependent not only on a specific etiologic diagnosis, but in the case of IOH, on an anatomic diagnosis to determine what level(s) is impaired in the autonomic reflex arc, as is elegantly summarized here by Fouad et al.

In the past, therapeutic efforts to maintain normal blood pressure have been largely disappointing. The general strategies have consisted of increasing blood volume, stimulating the alpha adrenergic system, or both. Recently, the alpha adrenergic agonist (midodrine) has shown some promise. Recumbent hypertension remains a serious problem.

If the somatic neurologic disorder of Shy-Drager accompanies the orthostatic hypotension, treatment is more complex. For example, agents such as levodopa that are used to ameliorate the extrapyramidal symptoms may aggravate the hypotension. Hence, the management of IOH and its various subsets remain a complicated and challenging task.